IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

July 17, 2007

Karen Smith, Administrator
3656 N 2500 E
Twin Falls, ID 83301

License #: RC-486

Dear Ms. Smith:

On April 26, 2007, a state licensure survey was conducted at Northern Light Residential Care Facility. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Donna Henscheid, LSW, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

DONNA HENSCHEID, LSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

DH/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program

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HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
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May 10, 2007

CERTIFIED MAIL #: 7003 0500 0003 1967 0803

Karen Smith, Administrator
Northern Light Residential Care
3656 N 2500 E
Twin Falls, ID 83301

Dear Ms. Smith:

Based on the state licensure survey conducted by our staff at Northern Light Residential Care Facility on **April 26, 2007,** we have determined that the facility failed to protect residents from inadequate care. Based on record reviews, observation, and interviews, it was determined the facility failed to provide adequate assistance and monitor medication for 3 of 3 sampled residents (#1, 2, 3). Further, the facility failed to implement care instructions for resident #3 as outlined in the resident's NSA. Finally, the facility failed to develop, track and review BMP's for 3 of 3 sampled residents (#1, 2, 3) to assist staff with resident behaviors.

This core issue deficiency substantially limits the capacity of Northern Light Residential Care Facility to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **June 10, 2007. We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **May 23, 2007,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**May 23, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **May 23, 2007,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **May 26, 2007**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Northern Light Residential Care Facility.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/slc

Enclosure

c: Debra Ransom, R.N., R.H.I.T., Chief, Bureau of Facility Standards
Sue Harvey, RN, Program Manager, Regional Medicaid Services, Region V - DHW

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R486	A. BUILDING _____ B. WING _____	04/26/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN LIGHT RESIDENTIAL CARE FACIL	964 BLAKE ST NORTH TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments A standard survey was conducted at your residential care/assisted living facility on April 26, 2007 during which the following deficiencies were cited. The surveyors conducting the standard survey were: Donna Henscheid, LSW Team Leader Health Facility Surveyor Maureen McCann, RN, BSN Health Facility Surveyor Karen McDannel, RN Health Facility Surveyor Survey Definitions: MAR = Medication Administration Record mg = milligrams mcg = micrograms NSA = Negotiated Service Agreement UAI = Uniform Assessment Instrument PRN = As Needed PSR = Psychosocial Rehabilitation RN = Registered Nurse BMP = Behavior Management Plan	R 000	RECEIVED MAY 25 2007 FACILITY STANDARDS	
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on record reviews, observations, and	R 008		

Bureau of Facility Standards

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R 008	Continued From page 1 interviews, it was determined the facility failed to provide adequate assistance and monitor medications for 3 of 3 sampled residents (Residents #1, 2 and 3). Further, the facility failed to implement care instructions for Resident #3 as outlined in the resident's NSA. Finally, the facility failed to develop, track and review BMPs for 3 of 3 sampled residents (Residents #1, 2 and 3) to assist staff with resident behaviors. I. ASSISTING AND MONITORING OF MEDICATIONS 1. On 4/25/07 at 10:50 a.m., review of Resident #3's record revealed the resident was admitted on 2/3/06 with diagnoses including: moderate mental retardation, atypical psychosis, hypertension, thyroid disease and psoriasis. On 4/25/07 at 11:55 a. m., review of Resident #3's physician's orders, April 07 MAR and the label on the resident's medi-set, revealed the following discrepancies: A. The following medications were listed on the MAR but there were NO written physician's orders in the resident's record: - Lisinop/HCTZ 20-12.5 2 tablets in the morning - Simvastatin 40 mg 1 tablet at bedtime - Nabumetone 750 mg 2 tablets in the morning for knee/back pain - Toprol XL 50 mg 1 tablet in the morning B. The following medications were NOT listed on the MAR but there were physician's orders in the resident's record: - Lipitor 10 mg by mouth 1 tablet daily - Amitriptyline 100 mg 1 tablet at night - Triamterene 1 tablet by mouth in the morning	R 008	R008 (#1) MEDICATION The Administrator of this facility must insure that polices and procedures are implemented to assure all residents receiving adequate care. The administrator will insure that all policies and proceedures are follllowed by all staff including contracted RN in regards to care as outlined in the NSA,medications,physicians orders and documentation.This will be monitored weekly by t he administrator and monthly by the RN. Ongoing contact between the administrator will take place as any changes are made in medication, resident well being and /or physicians orders Via phone contact,email or in person as needed. The facility contract Nurse (RN) will provide training on Medications, documentation, NSA Med assistance and delegations of such assistance to provide quality care to the residents in the facility. The RN will review staff ablity to follow delegations and document every 6 months to insure quality care of all residents.	6/1/07

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R 008	Continued From page 2 C. The following medications were listed on the MAR, but the physician's orders in the record indicated a DIFFERENT DOSE then on the MAR: i. The MAR listed: - Levoxyl (Synthroid) 175 mcg 1 tablet in the morning - Thioridazine 100 mg 1 tablet at bedtime ii. The physician's order's indicated: - Synthroid 137 mcg 1 tablet in the morning - Thioridazine 100 mg 2 tablets at bedtime D. Observation of the Resident #3's medi-set label revealed: i. The following did not have a physician's order: - Lisinop/HCTZ 20-12.5 tab 2 tablets in the morning - Simvastatin 40 mg 1 tablet at bedtime - Nabumetone 750 mg 2 tablet in the morning for knee/back pain - Toprol XL 50 mg 1 tablet in the morning ii. The following medication doses did not match the physician's order. - Levoxyl (Synthroid) 175 mcg 1 tablet in the morning - Thioridazine 100 mg 1 tablet at bedtime On 4/25/07 at 12:10 p.m., during an interview with the facility owner, she confirmed that Resident #3's physician's orders, April 07 MAR and the label on the resident's medi-set, revealed multiple discrepancies. She further stated that she could not explain why. On 4/25/07 at 4:00 p.m., the facility RN also confirmed that the physician's orders, April 07 MAR and the label on the resident's medi-set, revealed multiple discrepancies	R 008		

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R 008	Continued From page 3 E. Resident #3's April 07 MAR did not document the resident had been assisted with medication on the following dates: April 1, 2, 3, 4, 7 and 8. as well as on the evening of April 6th and the morning of April 9th. Upon request of previous MAR's, 2 other months were provided by the facility owner, however there was no month or year written on either MAR. One MAR was only filled out through the 14th of the month. The other MAR was not filled out on the following days: 1, 2, 3, 4, 5, 6, 15, 17, 18, 19, 20, 21, 24, 25, 27. Furthermore, it was not filled out for day shift on days 7, 11, 14, 26 or 28, nor for evening shift on days 10, 12 or 13. During an interview with the facility owner and facility RN on 4/26/07 at 4:00 p.m., they confirmed the MAR's had multiple areas left blank and they were not dated. Further, they stated did not know why. Because of the above medication discrepancies, the facility staff could not determine if the residents were getting medications as ordered by the physician, were getting accurate and consistent doses of the medications or were taking medications not ordered by the physician. 2. Review of Resident #1's record revealed the resident was admitted on 8/31/06 with the following diagnoses: mild mental retardation and bipolar disorder. Resident #1's NSA dated 9/13/06 documented the resident needed assistance with taking her medications. Review of Resident #1's April 07 MAR,	R 008		

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R 008	Continued From page 4 physician's orders and medi-set revealed the following discrepancies: A. Resident #1's April 07 MAR documented the following medications were being given by staff: - Seroquel 200 mg 2 tablets in the morning and 2 at bedtime - Effexor XR 75 mg 1 tablet in the morning - Trazodone 100 mg 1 tablet at bedtime - Lamictal 1 tablet in the morning - Ambien 5 mg 1 tablet at bedtime Resident #1's April 07 MAR did not document the resident had been assisted with medication on the following dates: April 1, 2, 3, 4, 7, 8, and the evening of the 24th. On 4/25/07 at 4:00 p.m., the owner stated the resident was out of the facility over Easter weekend (April 7 and 8), but was unable to explain the rationale for the blanks on the April 07 MAR for days 1, 2, 3, 4 or evening of the 24th or why staff had not documented when the medications were not given. B. Resident #1's record contained a physician's order dated 4/6/07 for the following medications: - Seroquel 400 mg 2 tablets at bedtime - Effexor XR 150 mg 1 tablet daily - Trazodone 100 mg 1 tablet at bedtime Resident #1's April 07 MAR documented the following medications were being given by staff: - Seroquel 200 mg 2 tablets in the morning and 2 at bedtime - Effexor XR 75 mg 1 tablet in the morning - Trazodone 100 mg 1 tablet at bedtime - Lamictal 1 tablet in the morning - Ambien 5 mg 1 tablet at bedtime	R 008		

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R 008	Continued From page 5 There was no physician order for the Lamictal and Ambien. Further, the physician's order for the Effexor XR and the Seroquel did not match the April 07 MAR. On 4/25/07 at 4:00 p.m., the facility's RN confirmed Resident #1's medications did not match the current physician's orders. C. On 4/25/07 at 11:45 a.m., observation of Resident #1's medications revealed Resident #1 had two medi-sets which contained only Ambien. One medi-set was labeled with a routine order for Ambien 5 mg at bedtime and the other labeled Ambien 5 mg PRN. On 4/25/07 at 11:45 a.m., a caregiver stated the reason there were two medi-sets with Ambien is because "the resident had filled her own." On 4/25/07 at 11:50 a.m., the administrator stated Resident #1 went to her mother's on 4/6/07 through 4/8/07, taking her medi-sets with her. The resident obtained additional medications from a physician which she used to fill the medi-sets. After returning to the facility, the resident had unlicensed staff assisting her with sorting out the medications she had from the physician and in the medi-set. The administrator stated on 4/19/07 she became aware unlicensed staff had assisted the resident with packaging her medications in the medi-set. For two weeks the resident had been assisted with the medications that were improperly packaged. 4/25/07 at 4:45 p.m., the facility RN stated she was not aware the resident had received double doses of her medications or had filled her own medi-set.	R 008		

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R 008	Continued From page 6 D. On 4/25/07 at 11:45 a.m., observation of Resident #1's medications revealed the number of a.m. and p.m. tablets in the medi-set did not match the amount of tablets listed on the MAR. Further the medi-set was labeled with week #3 instead of week #4. Also, the slots for the Sunday, Monday and Tuesday (4/22/07 thru 4/24/07 of that week) were still filled with tablets. On 4/25/07 at 4:00 p.m., the administrator stated Resident #1's current medi-set was taken to the pharmacy earlier on this day to be corrected because of the discrepancies found. Further, she stated she was unsure why the medi-set was labeled with the incorrect week and why the pharmacy filled for days that had already passed. 3. Review of Resident #2's record revealed the resident was admitted on 2/19/06, with diagnoses which included hypertension, history of seizure disorder and developmental delay. Resident #2's NSA dated 1/4/07, documented the resident needed assistance taking her medications. A physician's order dated 11/17/06, documented "Sinemet 25/100 mg 1 tablet PO at bedtime." A physician's order dated 4/24/07, documented "Increase Metoprolol 50 mg 1 tablet PO BID (twice daily) to Metoprolol 100 mg." The facility's April 07 MAR documented the resident was to receive "Carb/Leva 25 mg/200 mg 1 tablet at Bedtime and Metoprolol 50 mg 1 tablet morning, 1 tablet dinner." On 4/25/07 at approximately 11:45 a.m., the resident's medications were observed. The	R 008		

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R 008	Continued From page 7 medication in the medi-set did not match the medication orders from the physician or the MAR. The administrator stated she was not aware of the increase in the hypertensive medication "Metoprolol", nor could she explain the reason why the Carb/Leva dose did not match the physician's orders. Additionally the facility's MAR dated from April 1 through April 4 2007, was left blank, there was no documented evidence the resident had been assisted with medications during this time frame. On 4/25/07 at 3:57 p.m., the administrator was unable to explain the rationale for the blanks on the MAR, and could not determine why staff had not documented the medications not given to the resident during the four days. On 4/25/07 at 4:00 p.m., the facility's RN confirmed Resident #2 medications did not match the current physicians orders. Additionally, the facility RN stated she had not been monitoring the medication assistance program very closely. II. NSA IMPLEMENTATION: On 4/25/07 at 10:50 a.m., review of Resident #3's record revealed the resident was admitted on 2/3/06 with diagnoses including: moderate mental retardation, atypical psychosis, hypertension, thyroid disease and psoriasis. Resident #3's UAI dated 1/8/07, documented under the section titled, EATING, "needs stand by assist cueing, may have occasional gagging/choking or swallowing difficulties." Resident #3's NSA dated 2/19/07, documented under the section titled, EATING MEALS, "staff	R 008	R008 (#2) NSA This facility will insure that all policies and procedures are implemented and followed completley by all staff to insure adequate care is being provided to the residents within the facility. The Administrator will provide adequate training to all staff in regards to care and safety, ADL'S and NSA's. this will be done by in-service training for all staff at all levels of employment. Documentation of trainng reviews and changes in the NSA, New Admit and annualNSA will be placed in employee record.	6/1/07

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R 008	Continued From page 8 monitoring needed to cue [resident] to eat slower and to chew foods before swallowing. Staff needs to cut foods into small bite size pieces - on going daily." During the evening meal on 4/25/07 at 6:10 p.m., Resident #3 was observed eating her dinner rapidly. The meal included pork chops that were not cut up by staff. The caregiver serving the dinner meal did not intervene when the resident was eating rapidly, not following instructions outlined in the resident's NSA. These failures resulted in inadequate care because the facility failed to assure care instructions in Resident #3's NSA were implemented. Resident #3 was not assisted by staff during meals to decrease the risk of choking . III. BEHAVIORAL MANAGEMENT PLAN 1. On 4/25/07 at 10:50 a.m., review of Resident #3's record revealed the resident was admitted on 2/3/06 with diagnoses including: moderate mental retardation, atypical psychosis, hypertension, thyroid disease and psoriasis. Resident #3's UAI dated 1/8/07, documented under the section titled, BATHING, "becomes very agitated and self-abusive when in the tub. Staff has to be present and assist her with most tasks including drying herself off." Resident #3's NSA dated 2/19/07, documented under the section titled, BATHING, "due to diagnosis of self-abuse staff require to monitor....on-going daily." During a record review on 4/25/07, no	R 008	R008 (#3) Behavioral Management Plan The Administrator shall assess the need of all residents for BMP. If needed a BMP will be put into place as outlined in the NSA/UAI. Documentation of amount of occurances will be tracked and adjustments will be made as needed to fit the needs, safety and well being of each resident. The administrator will provide adequate training to all staff in regards to NSA, BMP and documentation. the administrator will review BMP monthly and insure staff is following the programs and documentation is being done correctly. The adminstrator will make any changes as needed and will inform th RN of these changes via phone,email and in person.	6/1/07

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R 008	Continued From page 9 documented evidence was found of a current Behavioral Management Plan, tracking of the resident's self-abusive behavior or staff assistance when the resident was showering. 2. Review of Resident #2's record on 4/25/07 revealed the resident was admitted on 2/19/06, with diagnoses which included hypertension, history of seizure disorder and developmental delay. Resident #2's NSA dated 1/4/07 documented the resident had behavior issues that required monitoring. Resident #2's UAI dated 1/8/07 documented the resident had behavior issues that required monitoring. Resident #2's record contained an "Individual Behavior Plan dated March 2007, which documented "The resident is rude to peers if they are in her way or if they want something and she feels they don't need it...She is direct and demanding with her words and forgets to use manners...Will get upset and cusses at staff and peers..." The behavior plan had instructions to staff how to intervene when the resident became angry. The plan included a positive reinforcement tool, and included a calender to track "Time Rudeness, Times Bossy or Pushy, and the staff initials." The behavior plan tracking form documented the resident had not displayed inappropriate behavior from March 1 through March 4 2007. The record did not contain a tracking form for April. On 4/25/07 at 11:00 a.m., the administrator confirmed that resident #2 still had behaviors but	R 008		

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NORTHERN LIGHT RESIDENTIAL CARE FACIL	964 BLAKE ST NORTH TWIN FALLS, ID 83301

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R 008	Continued From page 10 staff could intervene and diffuse the behavior. She further stated they did not have a current BMP for the resident nor was staff tracking her behaviors. On 4/25/07 at 2:45 p.m., Resident #2 was observed at her day treatment program. The resident stated she shared a bedroom at the facility and sometimes her roommate yells and is rude to her. On 4/25/07 at 3:00 p.m., the resident's day treatment instructor stated the resident does have times where she gets angry and overstimulated by the environment. The instructor stated the day treatment facility had an effective behavior management plan to ensure all staff were informed on how to intervene. Further, the instructor stated, "day treatment staff intervened quickly and were able to calm her down and redirect her behavior." 3. Review of Resident #1's record on 4/25/07 revealed the resident was admitted on 8/31/06 with the following diagnoses: mild mental retardation and bipolar disorder. Resident #1's NSA dated 9/13/06 and UAI dated 9/18/06 documented the resident had a history of violence, striking and lashing out when angry. Review of Resident # 1's record revealed no documented evidence of a behavior management plan. On 4/25/07 at 8:30 a.m., the owner and administrator confirmed Resident #1 did not have a BMP. Further the owner stated, "there were no BMPs for any of the residents, they're gone, they were shredded."	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R486	A. BUILDING _____ B. WING _____	04/26/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN LIGHT RESIDENTIAL CARE FACIL	964 BLAKE ST NORTH TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 11 These failures resulted in inadequate care because the facility failed to provide appropriate assistance and monitoring of medications for Resident #'s 1, 2 and 3 and failed to develop, track and review BMP's for Resident #'s 1, 2 and 3's behaviors. The facility RN did not consistently monitor residents' medications to validate the physician's orders against the medications being dispensed and failed to instruct caregivers how to safely assist with and document medications given. Further, the facility did not implement instructions to provide caregivers with guidance in managing resident behaviors or potential for behaviors.	R 008		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Northern Lights	964 Blake St N.	208 734-3537
Administrator	**City**	**ZIP Code**
Karen Smith	Twin Falls	83301
Survey Team Leader	**Survey Type**	**Survey Date**
Donna Henscheid	Standard	Apr 26 2007

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	221.01a	The facilities admission agreement does not reflect the current rules regarding 30 days notice for termination/discharge.		5/24/07 DH
2	260.06	The facility's interior and exterior were not maintained in a clean, safe and orderly manner: Exterior - the front and both back patios were dirty and covered with debris. The glass on the back patio wind barriers were filthy and some glass panes were cracked. The sliding glass door to the back patio was dirty. The refrigerator on the back patio was broken (door seal, plastic interior walls were cracked & duct taped). The interior also was filthy - covered with a brown substance. Food was being stored in this refrigerator). The barbeque grill was broken and was leaning against the building. Interior - the rug in the living room (room without TV) is ripped, the linoleum in the "staff" kitchen was ripped, the carpet in the TV room had a large stain on it		6/26/07 DH

Response Required Date	Signature of Facility Representative	Date Signed
May 26 2007	Karen Smith	4-26-07

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NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
(cont 2	260.06)	The couch and the loveseat in the TV room were torn. The wall in the TV room (on the right when entering from the kitchen) was spackled and stained with debris. Walls and doors throughout the facility had chipped, worn paint spots. A random checked telephone had been duct taped.		
3	305.03	One of three residents (#1), did not have documented evidence of a nursing assessment.		6/14/07 DH
4	305.08	The facility did not assess, document and recommend any health care related educational needs for staff.		6/26/07 DH
5	310.01	The facility was using bottle medications without a variance.		DH 6/14/07
6	310.01f	A caregiver assisted with medications did not observe a resident taken medication.		DH 6/26/07
7	310.03	The facility did not have a control substance tracking system and had many controlled medications on hand.		DH 6/26/07

Response Required Date	Signature of Facility Representative	Date Signed
May 26 2007	Karen Smith	4-30-07

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ASSISTED LIVING
Non-Core Issues Punch List

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Administrator	**City**	**ZIP Code**
Karen Smith	Twin Falls	83301
Survey Team Leader	**Survey Type**	**Survey Date**
Donna Henscheid	Standard	April 26 2007

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
8	310.04.E	The facility did not assure the physician was reviewing the use of psychotropic or behavior modifying medications at least every six months.		6/26/07 DH
9	350.02	The facility did not have documented incident reports for a fall Resident #3 sustained while in the facility.		6/26/07 DH
10	350.07	The facility failed to notify the Bureau of Facility Standards of an allegation of resident abuse.		6/26/07 DH
11	450	The facility did not meet the standards of the Idaho Food Code IDAPA 16.02.19. Refer to Idaho Food Code Inspection		5/24/07 DH
12	451.01.d	The facility did not track menu substitutions.		5/24/07 DH
13	550.06.b	The facility did not maintain a written record of all financial transactions involving 3 of 7 residents.		
14	625.01	2 of 2 staff records reviewed did not contain documented evidence of 16 hours of orientation training.		6/26/07 DH
15	630.02	2 of 2 staff did not receive mental illness or developmental training.		7/16/07 DH

Response Required Date	Signature of Facility Representative	Date Signed
May 26 2007	Karen Smith	4-26-07

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ASSISTED LIVING
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Karen Smith	Twin Falls	83301
Survey Team Leader	**Survey Type**	**Survey Date**
Donna Herscheid	Standard	April 26 2007

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
16	630.03	2 of 2 staff do not receive developmental disability/dementia training.		7/16/07 DH
17	640.	1 of 2 staff do not have documented evidence of 8 hours of CE training		
18	700	The administrator did not assure that facility policies and procedures for record keeping were implemented and followed		6/26/07 DH
19	711.08	The facility did not assure care notes were documented for 3 of 3 residents		7/16/07 DH
20	711.11	The Medication Administration Record did not accurately document medications - those taken, missed, or refused.		6/26/07 DH
21	711.12	PRN medications - there was no documentation for why these were taken		6/26/07 DH
22	725.01	The Admission and discharge register was not kept current		6/26/07 DH
23	730.02	The facility did not maintain 3 years of work records		6/26/07 DH
24	735.03	The facility did not maintain a perpetual record of drug disposal.		6/18/07 DH
25				

Response Required Date	Signature of Facility Representative	Date Signed
May 26 2007	Karen Smith	4-26-07